MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Sierra Medical Center P.O. Box 809053 Dallas, TX 75380-9053	MDR Tracking No.: M4-03-7936-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Co. Box 54	Date of Injury: Employer's Name: Power Tek Systems Insurance Carrier's No.: 99B0000309999

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/13/02	08/14/02	Inpatient Hospitalization	$63,261.32	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a Position Summary; however, the Requestor's rationale on the Table of Disputed Services states that the total charges on this bill exceed TWCC Sop Loss Clause of 40k.

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "…This dispute involves this carrier's payment for date of service 08/13/02-08/14/02 for which the requester charged $63,261.32 for one day inpatient stay for services that were NOT unusually extensive or costly and for a patient that was not even in ICU. In fact, the charge submitted as implantables in approximately 52% of the amount billed. However the requester did not attempt to substantiate that the charge of $32,573.12 is founded in reality. Therefore, this carrier reimbursed the requester, $6,492.57, a fair and reasonable reimbursement for implantables (estimated cost plus 10% in the absence of being provided invoices) and 1 days per diem based on the TWCC Acute Care In-Patient Fee Guideline…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 1 day (consisting of 1 day for surgical). Accordingly, the standard per diem amount due for this admission is equal to $1,118.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: The Requestor did not submit invoices for implantables or pharmaceuticals; therefore, MDR could not determine cost plus 10%.

The Requestor billed $63,261.32 and was reimbursed by the Respondent in the amount of $6,492.57. Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Marguerite Foster	03/17/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____